CITY OF BOSTON
COMPARISON OF HEALTH PLAN BENEFITS in effect as of July 1, 2013

The purpose of this benefit comparison is to provide employees with a brief overview of the benefits offered by the City's group health plans. This comparison does not represent complete plan benefits. Each plan's benefits are subject to certain definitions, limitations and exclusions as outlined in the respective plan documents. Should any questions arise concerning benefits, plan documents will govern. For those plans that require members to receive care through a network of health care providers in order to receive benefits, refer to the specific plan brochures for the list of participating providers.

Medical Plan **Monthly Rates**	**Blue Cross Blue Shield Blue Care Elect Preferred** $297.24 Ind / $689.64 Fam	**Blue Cross Blue Shield Blue Choice** $213.72 Ind / $551.48 Fam	**Harvard Pilgrim POS** $163.88 Ind / $440.88 Fam	**Boston Medical Center Advantage** $119.52 Ind / $321.52 Fam	**Harvard Pilgrim HMO** $119.52 Ind / $321.52 Fam	**Neighborhood Health Plan** $104.84 Ind / $277.84 Fam
Deductible *(per calendar year)*	In-Network: None Out-of-Network: $250 per member or $500 per family	In-Network: None Out-of-Network: $50 per member or $100 per family	In-Network: None Out-of-Network: $200 per member or $400 per family	None	None	None
Out of Pocket Maximum	In-Network: None Out-of-Network: $1,000 per member or $2,000 per family, for coinsurance only.	$2,450 per member or $4,900 per family, including the deductible, per calendar year for coinsurance only.	$1,500 per member or $3,000 per family, excluding the deductible, per calendar year.	$2,000 per member or $4,000 per family annual maximum; Excludes durable medical equipment and prescription drugs.	None	None
Preventive Care Visits & Health Screenings	$0 per visit	$0 per visit	$0 per visit	$0 per visit	$0 per visit	$0 per visit
Office Visits (Medical/ Mental Health/ Substance Abuse)	In-Network: $20 per primary care visit $20 per specialty care visit Out-of-Network: 80% coverage after deductible	In-Network: $15 per primary care visit $25 per specialty care visit Out-of-Network: 80% coverage after deductible	In-Network: $15 per primary care visit $25 per specialty care visit Out-of-Network: 80% coverage after deductible	BMC Advantage Network: $15 per primary care visit $15 per specialty care visit HPHC Provider Network (need referral): $25 per primary care visit $25 per specialty care visit	$15 per primary care visit $25 per specialty care visit	$15 per primary care visit $25 per specialty care visit
Prescription Drugs *(must be purchased from participating pharmacies unless otherwise noted)*	In-Network: Up to a 30-day supply at retail pharmacy: $10 – Tier 1 $25 – Tier 2 $45 – Tier 3 Mail (90 Days) $20/$50/$100 Out-of-Network: Not covered. Must use in-network pharmacy through Express Scripts, Inc.	In-Network: Up to a 30-day supply: $10 – Tier 1 $25 – Tier 2 $45 – Tier 3 Mail (90 Days) $20/$50/$100 Out-of-Network: Not covered. Must use in-network pharmacy through Express Scripts, Inc.	In-Network: Up to a 30-day supply: $10 – Tier 1 $25 – Tier 2 $45 – Tier 3 Mail (90 Days) $20/$50/$100 Out-of-Network: $5 - generic $10 – brand/formulary drugs $25 – brand/non-formulary drugs	Up to a 30-day supply: $10 – Tier 1 $25 – Tier 2 $45 – Tier 3 Mail (90 Days) $20/$50/$100	Up to a 30-day supply: $10 – Tier 1 $25 – Tier 2 $45 – Tier 3 Mail (90 Days) $20/$50/$100	Up to a 30-day supply: $10 – Tier 1 $25 – Tier 2 $45 – Tier 3 Mail (90 Days) $20/$50/$100

Medical Plan	Blue Care Elect Preferred	Blue Choice	Harvard Pilgrim POS	Boston Medical Center Advantage	Harvard Pilgrim HMO	Neighborhood Health Plan
Hospitalization (Medical/ Mental Health/ Substance Abuse)	In-Network: Covered in full Out-of-Network: 80% coverage after deductible. Covered in full for emergency/accident admissions.	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	BMC Advantage Network: Covered in full HPHC Provider Network: Covered in full after a $100 copayment per day up to a maximum copayment of $500 per member per calendar year.	Covered in full	Covered in full
Routine Pediatric Care	In-Network: $0 per visit Out-of-Network: 80% coverage after deductible. Both In & Out-of-Network according to schedule: 10 visits in first year; 3 visits in second year; 1 visit per calendar year ages 2 – 18.	In-Network: $0 per visit Out-of-Network: 80% coverage after deductible according to schedule: 6 visits in first year (less any inpatient visits); 3 visits in second year; 1 visit per year age 2 through age 5.	In-Network: $0 per visit Out-of-Network: Full coverage after deductible according to schedule: 6 visits in first year; 3 visits in second year; 1 visit per year age 2 through age 6.	BMC Advantage Network: $0 per visit HPHC Provider Network: Covered in full.	$0 per visit	$0 per visit
Adult Physicals	In-Network: $0 per visit Out-of-Network: 80% coverage after deductible. 1 visit per calendar year for In & Out-of Network combined.	In-Network: $0 per visit Out-of-Network: Not covered	In-Network: $0 per visit Out-of-Network: Full coverage after deductible	BMC Advantage Network: $0 per visit HPHC Provider Network: Covered in full.	$0 per visit	$0 per visit
Emergency Room	In-Network: $100 per visit Out-of-Network: $100 per visit	In-Network: $100 per visit Out-of-Network: $100 per visit for approved emergency care in an emergency room; otherwise, 80% coverage after deductible.	In-Network: $100 per visit Out-of-Network: $100 per visit for treatment of life-threatening illness or injury; 80% coverage after deductible for other care.	BMC Advantage Network: $100 per visit HPHC Provider Network: $100 per visit	$100 per visit	$100 per visit
Ambulance Services	In-Network: Covered in full Out-of-Network: Covered in full for accident or emergency;80% coverage after deductible for other medically necessary transport	In-Network: Covered in full Out-of-Network: Covered in full for emergency transport; 80% coverage after deductible for other medically necessary transport	In-Network: Covered in full Out-of-Network: Covered in full	BMC Advantage Network: Covered in full HPHC Provider Network: Covered in full	Covered in full	Covered in full
X-Ray and Lab	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	BMC Advantage Network: Covered in full HPHC Provider Network: Covered in full	Covered in full	Included in office visit
Chiropractic Care	In-Network: $20 per visit Out-of-Network: 80% coverage after deductible	In-Network: Not covered Out-of-Network: 80% coverage after deductible	In-Network: Not covered Out-of-Network: 80% coverage after deductible	$25 per visit for up to $1,000 per member per calendar year for covered services received from a participating chiropractor.	Not covered	Not covered

	Blue Care Elect Preferred	Blue Choice	Harvard Pilgrim POS	Boston Medical Center Advantage	Harvard Pilgrim HMO	Neighborhood Health Plan
Durable Medical Equipment	In-Network: Covered in full for up to $1,500 per member per calendar year. Out-of-Network: 80% coverage after deductible for up to $1,500 per member per calendar year. In & Out-of-Network maximum combined.	In-Network: 80% coverage for up to $1,500 per member per calendar year. Out-of-Network: 80% coverage after deductible for up to $1,500 per member per calendar year.	In-Network: Covered in full Out-of-Network: 80% coverage after deductible.	BMC Advantage Network and HPHC Provider Network: Covered in full after a copayment of 20% not to exceed a member's total expense of $1,000. After that, benefits are covered in full.	Covered in full	Covered in full
Home Health Care	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	In-Network: Covered in full Out-of-Network: 80% coverage after deductible	BMC Advantage Network: Covered in full HPHC Provider Network: Covered in full	Covered in full	Covered in full
Physical Therapy	In-Network: $20 per visit Out-of-Network: 80% coverage after deductible In & Out-of-Network maximum combined benefit of 100 visits per calendar yr	In-Network: $15 per visit for up to 90 consecutive days per condition. Out-of-Network: 80% coverage after deductible	In-Network: Same as Harvard Pilgrim HMO benefit Out-of-Network: 80% coverage after deductible.	BMC Advantage Network: $15 per visit for up to 90 consecutive days per condition. HPHC Provider Network: $25 per visit for up to 90 consecutive days per condition.	$15 per visit for up to 60 consecutive days per condition.	$15 per visit for up to 90 consecutive days
Vision Care	In-Network: Covered in full Out-of-Network: 80% coverage after deductible. 1 visit per 24 months; In &Out-of-Network combined.	In-Network: Full coverage for one routine vision exam per calendar year. Out-of-Network: No coverage for routine care. Discounts on eyeglasses and contact lenses from participating providers.	In-Network: $25 per visit Out-of-Network: 80% coverage after deductible Discount on eyewear from participating providers.	BMC Advantage Network: Annual eye exam at $15 per visit. HPHC Provider Network: Annual eye exam at $25 per visit. Discount on eyewear from participating providers.	Annual eye exam at $15 per visit	$25 per visit for annual routine eye exam
Dental Care	Not covered	In-Network: Preventive dental care for children under age 12. Out-of-Network: Not covered	In-Network: Same as Harvard Pilgrim HMO benefit Out-of-Network: Not covered	None	2 preventive dental exams per calendar year, for adults and children. Thru age 12: No charge Age 12 & up: $10/visit	One preventive dental care visit every six months for children under age 12. No co-payment..

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